

## Access to Care among Medicare Beneficiaries With and Without Depression

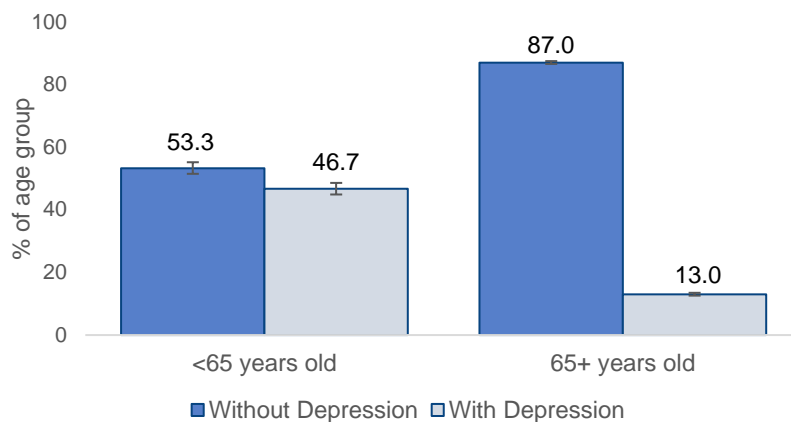
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Depression is a common and very serious condition in the United States that affects how a person feels, thinks, and functions with routine activities, such as sleeping, eating, or working.<sup>1</sup> Depression and other serious mental disorders are among the qualifying conditions for disability coverage through the Social Security Administration, upon which eligibility for Medicare coverage for persons under age 65 is based.

Patients with depression and other mental health disorders experience barriers to care, such as provider shortages, stigma attached to psychiatric diagnoses, and lack of transportation.<sup>2-5</sup> This report describes barriers in accessing care among Medicare beneficiaries with and without depression.

**Medicare Beneficiaries under age 65 years, who were entitled to Medicare due to a qualifying disability, were more likely to report being depressed compared to older beneficiaries.**

Figure 1. Percentage of community-dwelling Medicare beneficiaries with and without depression by age (2011-2013)



SOURCE: Medicare Current Beneficiary Survey, 2011-2013 Access to Care.

Depression was significantly more prevalent in the <65 age group than the 65+ age group ( $p < 0.01$ ; adjusted Wald Test). 95% confidence intervals are represented with error bars.

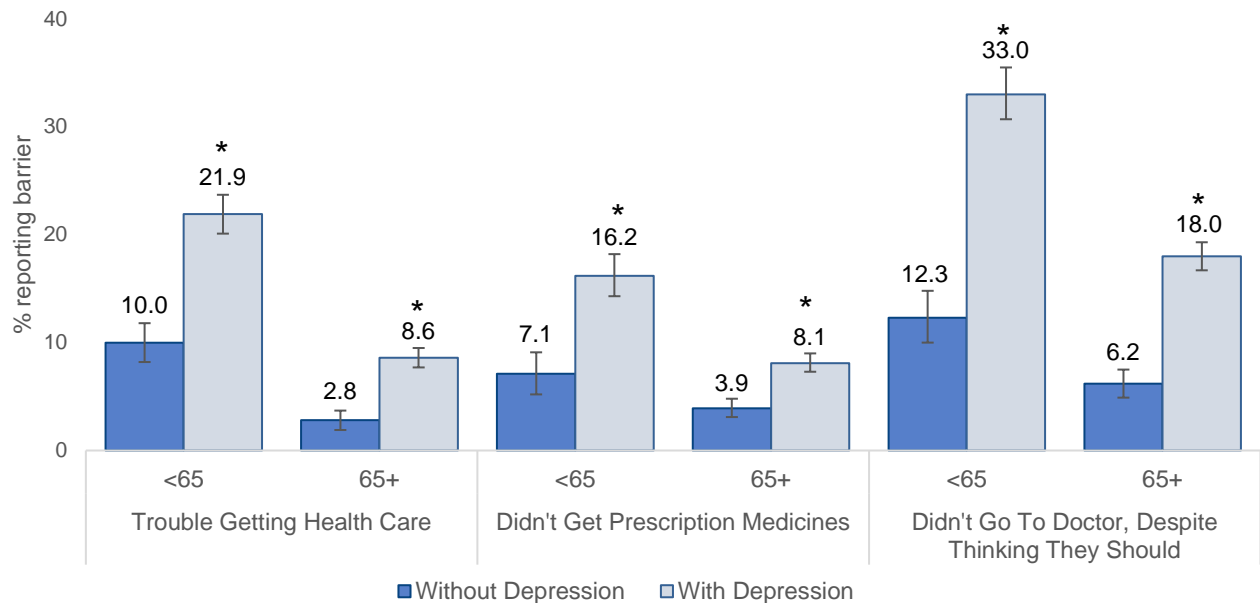
### KEY FINDINGS

#### Data from the Medicare Current Beneficiary Survey

- Among Medicare beneficiaries age 65 years or older, 13.0% reported depressive symptoms, compared to 46.7% of Medicare beneficiaries under age 65 years, who were entitled to Medicare due to a qualifying disability.
- Beneficiaries with depression, regardless of age, were more likely to report having trouble getting health care, obtaining prescription medicines, and not seeing doctors than those without depression.
- Beneficiaries with depression, regardless of age, were more likely to report that they have no usual source of care due to high cost.

**Beneficiaries with depression reported barriers accessing care compared to beneficiaries without depression.**

Figure 2. Percentage of community-dwelling Medicare beneficiaries reporting barriers accessing care by age and depression status (2011-2013)



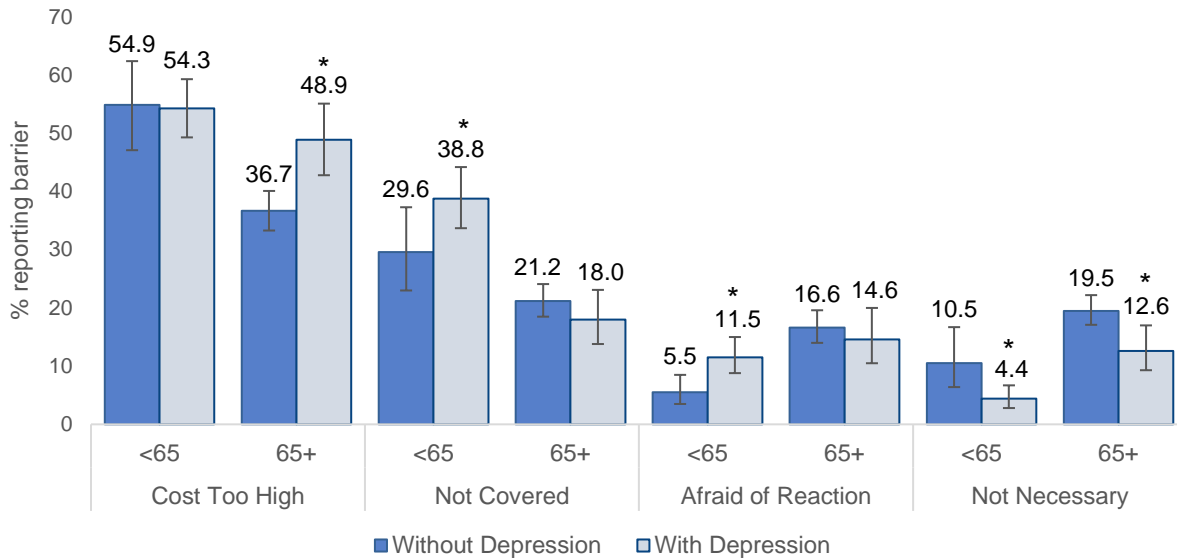
SOURCE: Medicare Current Beneficiary Survey, 2011-2013 Access to Care.

\*p<0.05 (p-values from adjusted Wald test; 'Without Depression' is the reference group)

- During 2011-2013, beneficiaries with depression, regardless of age, were more likely to experience barriers to care across three common access measures: (1) trouble getting care, meaning that they couldn't get the health care that they wanted or needed; (2) not obtaining prescriptions, meaning that there were prescribed medications that they did not get, including refills; and (3) didn't go to the doctor, despite having a problem or condition that they thought should have been seen by a doctor.
- Among beneficiaries less than 65 years of age with depression, more than one out of five (21.9%) reported trouble getting health care and one out of three (33.0%) reported not seeing a doctor.
- Among beneficiaries 65 years or older with depression, 16.2% did not get a medication prescribed for them and 18.0% reported not seeing a doctor.

**Costs and lack of coverage reported as reasons for not obtaining prescriptions among Medicare beneficiaries with depression.**

Figure 3. Reported reasons for not obtaining prescriptions, among community-dwelling Medicare beneficiaries who did not obtain prescribed medications, by age and depression status (2011-2013)



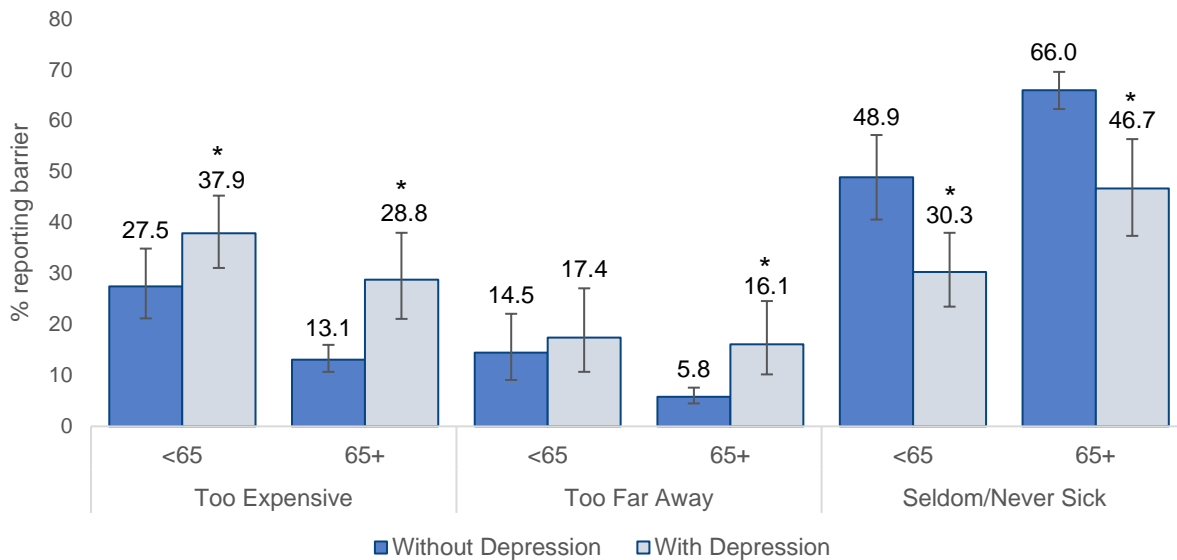
SOURCE: Medicare Current Beneficiary Survey, 2011-2013 Access to Care.

\*p<0.05 (p-values from adjusted Wald test; 'Without Depression' is the reference group)

- Among beneficiaries 65 years or older who reported not obtaining prescribed medications, those with depression were more likely to report that the cost was too high.
- Among beneficiaries less than 65 years of age who reported not obtaining prescribed medications, those with depression were more likely to report they did not get prescribed medicines because they were not covered (38.8% vs. 29.6% for beneficiaries without depression) or because they were afraid of a reaction (11.5% vs. 5.5% for beneficiaries without depression).
- Among beneficiaries in both age groups who reported not obtaining prescribed medications, those with depression were less likely to report that the medications were not necessary.

**For beneficiaries with no usual source of care, those with depression reported care too expensive as a reason.**

Figure 4. Reported reasons for not having a usual source of care, among community-dwelling Medicare beneficiaries who did not have a usual source of care<sup>§</sup>, by age and depression status (2011-2013)



SOURCE: Medicare Current Beneficiary Survey, 2011-2013 Access to Care.

<sup>§</sup> 4.4% of Medicare beneficiaries report not having a usual source of care.

\*p<0.05 (p-values from adjusted Wald test; 'Without Depression' is the reference group)

- For beneficiaries without a usual source of care, those with depression in both age groups were more likely to report no usual source of care because it was too expensive.
- Beneficiaries with depression 65 years or older were more likely to report no usual source of care because such sources of care were too far away (16.1% vs. 5.8% for beneficiaries without depression).

**SUMMARY**

Beneficiaries with depression, regardless of age, more often reported having trouble getting health care, compared to beneficiaries without depression. Beneficiaries with depression reported they were accessing or seeking care significantly less often than beneficiaries without depression. The specific barriers beneficiaries with depression gave for not getting care included cost, prescriptions not being covered, and a general avoidance of the doctor. Identifying this unmet need for beneficiaries with depression is an essential first step in beginning to address their barriers to getting care.

The findings reported here may be sensitive to how depression is defined. The MCBS data from community-dwelling beneficiaries are self-reported, which may cause the prevalence of depression presented in this brief to differ from prevalence estimates based on clinical and/or administrative data.

## DEFINITIONS

**Depression** – We used two MCBS questions to identify beneficiaries with depression: (1) “In the past 12 months, how much of the time did you feel sad, blue, or depressed? Would you say you were sad or depressed all of the time, most of the time, some of the time, a little of the time, or none of the time?” and (2) “In the past 12 months, have you had 2 weeks or more when you lost interest or pleasure in things that you usually cared about or enjoyed?” If a beneficiary answered “all of the time” or “most of the time” to the first question, and/or answered “yes” to the second question, then the beneficiary was defined as having depression in the MCBS data.<sup>6-7</sup> Users should note that in 2016, the two depression symptom measures in the MCBS were replaced with the more standardized Patient Health Questionnaire Mood Scale (PHQ-9) questions.<sup>8</sup>

**Access to care** – We identified four MCBS measures that assess access to care: 1) had trouble getting care; 2) did not obtain prescribed medications; 3) did not see a doctor when they thought they should; and 4) had a usual source of care. For the first three measures, if beneficiary responded “Yes”, then the beneficiary was defined as having a barrier to care. For the usual source of care, if a beneficiary responded “No”, the beneficiary was defined as not having a usual source of care. Beneficiaries who indicated barriers to care or not having a usual source of care were asked a series of follow-up questions regarding the reasons they did not access care (e.g. cost, lack of transportation, patient preferences, etc.). The follow-up questions were asked separately and, thus, were not mutually exclusive.

## DATA SOURCES AND METHODS

We analyzed data from the 2011-2013 Medicare Current Beneficiary Survey (MCBS), an in-person, nationally-representative, longitudinal survey of Medicare beneficiaries that is sponsored by the Centers for Medicare & Medicaid Services (CMS) and directed by the Office of Enterprise Data and Analytics (OEDA). The MCBS is the most comprehensive and complete survey available on the Medicare population and is essential in capturing data not otherwise collected through operations and administration of the Medicare program. The MCBS contains detailed information on depression diagnoses, depressive symptoms, and self-reported access to care barriers.

The MCBS employs a rotating panel design in which beneficiaries remain in the sample for a maximum of four years. Each year, beneficiaries who remained in the sample for up to four years exit the sample, and a new sample of beneficiaries are selected to replace those exiting the sample (roughly one-fourth of the sample is replaced each year). This analysis was based on a pooled cross-sectional design. We pooled three years of data to increase the sample size and improve the reliability of our findings across each of the four residential status categories of interest. We used cross-sectional survey weights to account for overall selection probability of each sample person and include adjustments for the stratified sampling design, survey nonresponse, and coverage error. As a result of this pooling, many

respondents appeared more than once in our analytic sample. Balanced repeated replication (BRR) weights were used for variance estimation. This variance estimation method accounted for non-independence of the person-years in the multi-year, pooled dataset. These statistical methods yielded a pooled estimate that is in effect a moving average of nationally representative year-specific estimates. The pooled estimate can be interpreted as being representative of the midpoint of the pooled period. All analyses were stratified by beneficiary age (under 65 years vs. 65 years or older).

Although 95% confidence intervals are presented in the Figures, adjusted Wald tests were used to test for statistically significant differences in proportions across groups.<sup>9</sup> These tests adjust the degrees of freedom to account for the complex survey design.<sup>10</sup> All significant findings cited in-text are statistically significant at the  $p < 0.05$  level unless otherwise stated. Since the analytic dataset had negligible rates of item nonresponse (less than 1%), we performed complete case analysis using appropriate sub-population or domain statements to ensure no observations were excluded from the survey-weighted analyses. SAS 9.4 was used to construct analytic datasets and Stata 13.1 was used to conduct the analyses.

**Study Population.** The sampling frame for this analysis included all Medicare beneficiaries enrolled in the Medicare program at any time during 2011-2013 and living in the community (i.e., not living in a facility). To construct the pooled analytic dataset, relevant MCBS segment files were first linked to the cross-sectional survey weights file for each year in the pooled period. This resulted in three year-specific analytic datasets (i.e., 2011, 2012, and 2013), which we appended to produce the pooled cross-sectional analytic dataset. The final pooled dataset includes 42,233 person-years (weighted  $N = 135,418,967$ ).

## ABOUT THE AUTHORS

This report was written under contract number HHSM-500-2014-00035I/T0002 by Erin Ewald, Sai Loganathan, and Jennifer Hasche of NORC at the University of Chicago, in collaboration with Kimberly Lochner at the Centers for Medicare & Medicaid Services (CMS) Office of Enterprise Data and Analytics (OEDA).

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